Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: AMIR MOHAMED 3615 19TH STREET LUBBOCK TX 79410	MFDR Tracking #: M4-11-1920-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE COMPANY Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "Claim was submitted in a timely manner. Proof of timely filing was provided yet claim still denied."

Amount in Dispute: $13,917.85

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided inpatient treatment of the claimant from 10/20/08 through 10/23/08. The requestor states in its DWC-60 packet the employer requested the billing be sent to them. However, after this was done someone determined the employer was not responsible for the bill. The requestor further states it submitted the bill timely to Texas Mutual on 12/12/08. While that is true, the bill also was incomplete and was returned. The requestor submitted a complete bill to Texas Mutual which was received 6/19/09. Because it was past the 95 days specified by Rule 133.20, Texas Mutual declined to issue payment. Rule 133.307 at (c)(1)(A)(B) states in part: Request for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division…(1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section received the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability, (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity; or (iii) the dispute related to a refund notice issued pursuant to a Division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice. None of the exceptions appear to apply. The disputed dates are 10/20/08 through 10/23/08. The DWC MDR dated stamp lists January 2011 as the time frame for receipt of the requestor's request for medical fee dispute resolution, which is beyond the one year filing deadline."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
10/20/2008 Through 10/23/2008	Hospital Inpatient Surgical Services	Not Applicable	$13,917.85	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. The disputed services were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 07/14/2009 noted claim reduction codes:
   - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 731 – 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE FOR SERVICE ON OR AFTER 9/1/05.

   Explanation of benefits dated 12/03/2009 noted claim reduction codes:
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 731 – 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE FOR SERVICE ON OR AFTER 9/1/05.
   - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.

   Explanation of benefits dated 12/08/2009 noted claim reduction codes:
   - 193– ORIGINAL PAYMENT DECISION IS BEING MAINTAINED UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 731 – 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE FOR SERVICE ON OR AFTER 9/1/05.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

Issues

1. Did the requestor submit the Request for Medical Fee Dispute Resolution in accordance with 28 Tex. Admin. Code §133.307?
2. Is the requestor entitled to reimbursement for the service billed?

Findings

1. The Division received a request for medical fee disputed resolution on January 31, 2011; Amir Mohamed submitted bills from Covenant Medical Center with date of service 10/20/2008 through 10/23/2008. Pursuant to 28 Tex. Admin. Code §133.307(c)(1)(A) requests for medical fee dispute resolution that do not involve extent of injury or medical necessity shall be filed no later than one year after the date of service in dispute.
2. Pursuant to 28 Tex. Admin. Code §133.307(c)(1), a requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The disputed dates of service 10/20/2008 through 10/23/2008 were not timely filed and therefore the requestor has waived their right to MDR for these dates of service. The Division concludes that the requestor has failed to support that the services are eligible for medical fee dispute resolution under 28 Tex. Admin. Code §133.307.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sections 413.011(a-d), 413.031, 413.0311
28 Texas Administrative Code §133.305, §133.307, §133.20

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**08/31/2011** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.